

February 11, 2013

Dear Senate Judiciary Committee Member,

Assisted Suicide is an important topic for Montana, where most of the population is over 50 years of age.

I retired from the Motion Picture Pension and Health Plans in Studio City, California, as the Chief Financial Officer. One reason my wife and I retired to Montana was we had the perception that Montana was senior-citizen friendly, i.e., unlike Oregon and Washington, which had adopted laws allowing doctors and family members to assist people in killing themselves. That was repugnant to us.

The proposed legislation is for terminally ill persons. "Terminally ill" is a term I am all too familiar with. In my previous employment, one would need to be terminally ill to qualify for a pension, if they had not reached a specified ^{age}. Many, many times doctors would deem someone terminally ill and they wound up living many years, ~~some even returned to work~~. If these persons had instead been applying for a lethal dose and used it, they would be dead before their time.

Doctors are held in high esteem by the public but they would significantly undermine the public trust in their profession by aiding in killing their patients.

Therefore, I urge you to vote NO on SB220.

Sincerely,
Ted Friesen
Bigfork, Mt.

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Please Step Back From the Assisted-Suicide Ledge ^{10/8/12} _{WSJ}

By **Tadeusz Pacholczyk**

In the November elections, voters in Massachusetts will decide on "Question 2," a ballot initiative to allow physicians to prescribe (but not administer) a lethal dose of a toxic drug to assist their patients in committing suicide. Advocates of physician-assisted suicide assure us that this can be a good choice for someone who is dying, or who wants to die.

If physician-assisted suicide really represents a good choice, we need to ask: Why should only physicians be able to participate? Why should only physicians be allowed to undermine public trust in their profession through these kinds of death-dealing activities?

Why not include police? If a sick person expresses a wish to die, the police could be notified, and an officer would arrive bearing a suitable firearm. He would load it with ammunition, cock the gun and place it on the bedside stand of the sick patient. After giving instruction on the best way to angle the barrel, the officer would depart, and the patient could then pick

up the device and take it from there—police-assisted suicide.

The assisted-suicide paradigm readily admits of other creative approaches as well—we could sanction, for example, assisted drownings, with lifeguards asked to help those wishing to die by providing millstones to take them to the bottom of lakes and oceans.

If a lifeguard helped people drown, though, would you want him watching your family at the beach?

It is troubling how many individuals fail to grasp the absurdity of encouraging physician-assisted suicide. Suicide is no joking matter. Regardless of how it transpires, it is a catastrophe for those who end their own lives and for loved ones left behind.

Some people may decide that their lives are no longer worth living. But our society has always recognized that decision to be a tragedy and a mistake. That's why high bridges have signs encouraging suicidal individuals to seek help rather than jump. Suicide hotlines are open 24 hours a day because we seek to prevent as many deaths as we can. We treat as heroes those who walk along bridges or climb tall buildings and try to talk people down.

Writing at the Public Discourse website, commentator Greg Pfundstein has emphasized how this sound and consistent cultural message is flatly

contradicted when we allow physicians to prescribe lethal drugs so people can kill themselves. It is like replacing the suicide-intervention signs on bridges with signs that state: "Ask your physician if jumping is right for you."

Such jumping is never a "good

Why should doctors have a monopoly on undermining public trust in their profession by aiding suicides? Police and lifeguards could help out too.

thing," and it is only our own foolishness that lets us feign that it could be, whether physician-assisted or otherwise.

I remember reading a letter to the editor in the local paper of a small town many years ago. A woman wrote in about the death of her grandparents—well-educated, intelligent and seemingly in control of their faculties—who had tragically committed suicide together by drinking a deadly substance. They were elderly and struggling with various ailments.

Her firsthand perspective was unflinching: It took her years to forgive her grandparents. She was angry at what they had done to her and her

family. She felt betrayed and nauseated. She could hardly believe it had really happened.

The woman was still upset that they hadn't reached out to the rest of the family for assistance. She dismissed the idea that suicide could ever be a good thing as a "total crock and a lie," noting how it leaves behind deep scars and immeasurable pain on the part of family and friends. Without demurring, she declared that we don't have the right to take our own lives because we didn't give ourselves life.

A friend of mine in Canada has struggled with multiple sclerosis for many years. He often speaks out against assisted suicide.

Recently, he sent me a picture of himself taken with his smiling grandchildren, one sitting on each arm of his wheelchair. Below the picture he wrote, "If I had opted for assisted suicide back in the mid-1980s when I first developed MS, and it seemed life as I knew it was over, look what I would have missed. I had no idea that one day I would be head over heels in love with grandchildren! Never give up on life."

Fr. Pacholczyk, the director of Bioethics Center at the National Catholic Ph.D. in neuroscience from Yale. He is a priest in the diocese of Fall River, Mass.